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# SAJOUS'S
# ANALYTIC CYCLOPEDIA
OF
# PRACTICAL MEDICINE

BY
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## GENERAL INDEX

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# SAJOUS'S ANALYTIC CYCLOPEDIA *of* PRACTICAL MEDICINE

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**Headache.**

**Etiology.**—Headache may be due to numerous and varied agencies. Lesions of the brain, meninges, cranium, scalp, eye, ear, sinuses, nose, teeth, etc., in which pain is caused through direct or indirect involvement of sensory nerves; various diathetic diseases, especially gout, rheumatism and syphilis; tumors, abscesses, abnormal intracranial tension, traumatisms, cutaneous irritation (as by pediculi capitis), tight or heavy headwear; blood-disorders, plethora, the anemias, cardiovascular and renal disorders; toxics, especially alcohol and tobacco; emotions, intellectual effort, muscular exertion, heat, cold, low barometric pressure, etc.; various forms of indigestion, gastric or intestinal, or both, represent but the more frequent causes of this frequently encountered symptom.

To these more familiar causes several that had previously attracted but scant attention have lately been emphasized. Harvey Cushing (Boston Med. and Surg. Jour., Mar. 2, 1916) recalls that the brain itself is insensitive, while the *dura mater* is extremely so. The headaches of *pregnancy* come on at a time when the pituitary is enlarged, and in similar ways one may often attribute headache to *dural stretching.* The region of the foramen magnum is supplied by the vagus, and in *gastric disorders* pain is often referred to this region. Changes in *cerebrospinal fluid pressure* may give headache; likewise, the *cerebral edema* accompanying many states, such as poisoning by alcohol, ether, and other drugs. On some of these conditions there may be merely an increase in the fluid from the plexuses. E. Jones (Jour. of Ophth., Otol. and Laryn., xxii, 76, 1916) states that in headache due to the *maxillary sinus,* there is a full tense feeling over the superior maxillary region of the affected side or pain pressing upward to the outer angle of the eye. Headache in *acute frontal sinusitis* is present from the start, first over the sinus, later in the vertex, temporal, or occipital regions. In *anterior ethmoid diseases* there is pain between the eyes; when behind the eyes and nose there may be trouble with the *posterior ethmoid cells.* The headache in *sphenoidal disease* is most excruciating within the head and through the temples or occipital regions. W. Freudenthal (N. Y. Med. Jour., Jan. 1, 1916) holds that when headache is present on awakening, a *nasal disorder* is a possible source. If cocainization of the nose reduces the headache, its nasal origin is the more likely; also if it increases when certain diseased areas are touched with the probe. The region most active in causing headache is not the nose but the *nasopharynx;* by treating it physicians could relieve 50 per cent. of all sufferers from headache. Ocular headaches may be the result, according to

Bedell (Albany Med. Annals, May, 1916), of a *refractive muscle* error or *local inflammation.* Occipital pain and nape of the neck discomfort, extending even to the shoulders, is often of ocular origin. Although most common in the afternoon, they may occur at any time. It may be present even with perfect distant and near vision. The eye should not be excluded until a cycloplegic has been used.

The continuous *morning headaches with high blood-pressure* were studied by Rénon (Paris méd., July 1, 1916). This special type occurs in persons between 45 and 60 with arteriorenal sclerosis, due either to interstitial nephritis from scarlet fever in childhood, imperfectly treated syphilis, tobacco poisoning or excessive meat eating, to all of which a sedentary life, cares, and excessive mental work may be co-operating factors. The diastolic blood-pressure is quite high in these cases. The headache may be diffuse, though sparing the occiput, or localized. It wakes the patients at 5, 6, or 7 o'clock, grows worse toward 9 and 10, and gradually subsides by noon or 1 o'clock. It may be of sufficient intensity to render all physical or mental work impossible.

**Treatment** of the form due to arteriorenal sclerosis described by Rénon includes weaning the patient from headache remedies and tobacco. Physical and mental repose should be enforced, keeping the patient on an exclusive **milk diet** for a week, 2 liters (quarts) in the 24 hours, adding to each liter (quart) 2.5 Gm. (38 grains) of **sodium citrate.** In the following 2 weeks only milk should be allowed on 2 days each week, with a **fruit and vegetable diet** the other days. By the end of the third week, a mixed diet can be resumed, allowing meat only once a day, at midday. Salt should be used sparingly. If the headache persists, and the minimal pressure keeps high, **thiosinamine** is given, and kept up a long time.

Probably the most stubborn form of headache encountered is met in persons whose health seems in no way impaired. There is merely, as an incident of advancing age, the debilitating influence of arduous occupation, social exigencies, etc., a slight reduction in the power to carry on the various functions, including that of preparing adequately for assimilation all the food products admitted to the intestinal canal. Even at best such is seldom the case among the well-to-do classes. Various observers have estimated that one-tenth to one-seventh of the food ingested fails to be acted upon by the digestive ferments. This undigested fraction is retained sufficiently long in the intestine to be broken down by bacteria, particularly the putrefactive anaërobes, aided by the colon bacillus. To the resulting toxic products true dietetic headache is usually traceable.

While normal individuals are able either to excrete actively or break down these toxic products, the subjects in question can only excrete or hydrolyse a fraction or none at all of these substances.

Whatever proportion of the latter is present in the blood, gives rise to the headache—usually a severe hemicrania coming on early in the morning, and sometimes persisting all day.

The treatment of these cases is satisfactory and simple. It consists: 1, in administering a saline purgative to clear the intestine of any putrefactive remnants; 2, in abstaining from foods rich in proteids, meat, eggs, etc., at the evening meal—an essential feature, since the depression of activities which sleep entails is the cause of the accumulation of toxic wastes which engender the headache; 3, in taking 1 grain (adults), morning and evening during meals, of the **desiccated thyroid gland** to enhance the catabolism of toxic wastes.

A cause of headache frequently overlooked is sleeping with the head too high. This gives rise, especially during the early morning hours, when the blood-pressure is low, to ischemia of the superficial nerves and therefore to neuralgia (*q.v.*).

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**Etiology.**—Besides the references to this symptom throughout the work under the various disorders in which it is observed, several interesting points have recently been recorded. The blood from the stomach may be bright red, or occur as a reddish fluid with brownish and reddish clots, or as a brownish fluid with coffee-grounds material, or as red clots in ordinary vomitus. The chief factor in its appearance is the time it has been exposed to the gastric ferment. Slight hemorrhage may be derived, according to Cross (L. I. Med. Jour., Jan., 1917), merely from a congested stomach subjected to repeated vomiting or retching. Rupture of an aneurism into the stomach or esophagus usually, but not always, results in copious hematemesis. Bleeding from a gastric or duodenal ulcer is likely to be considerable. In malignant growths of the esophagus or stomach vomiting of coffee-grounds material occurs in 60 per cent. of cases; occasionally there is a large hemorrhage. Copious bleeding may come from engorged gastric or esophageal veins in cirrhosis of the liver. Enlargement of the spleen and mitral stenosis are also possible causes. In purpura, scurvy, hemophilia, primary anemias, and chronic nephritis, gastric hemorrhage may result from chemical alteration in the blood. Other causes are corrosive poisons, acute bacillary gastritis, acute infections, and vicarious menstruation.

Referring to hematemesis due to hepatic cirrhosis, Balfour (Trans. Amer. Med. Assoc.; N. Y. Med. Jour., June 9, 1917) cites the accumulating evidence that the spleen is responsible for certain types of hepatic cirrhosis, and that early splenectomy will probably prevent further liver changes. That gall-bladder infection and appendicitis may be directly responsible for hematemesis has been shown by results of operations. It is more than very probable, however, that these or other foci cause the gastric bleeding by first setting up toxic changes in the liver. Moschkowitz (Amer. Jour. Med. Sci., Nov., 1916) refers to cases having no complaints referable to the stomach, and in which suddenly, without warning, the patient vomits blood profusely. Profound anemia follows. Examination of the stomach reveals nothing noteworthy. The disease is most frequent in females in the early twenties. In each of the writer's cases the abdomen was opened, but no evidence of ulcer could be found. All recovered.

A case of death from hematemesis beginning the third day after chloroform narcosis is reported by J. Jedlicka (Casop. lek. cesk., No. 34, 1916). Autopsy showed that the chloroform had caused fatty degeneration of various organs, especially the gastric and duodenal mucosa, and that the gastric juice had caused a circumscribed digestion in the areas of fatty degeneration down to the vessels.

**Treatment.**—In a case of hematemesis occurring 6 hours after gastroenterostomy in a young man, arrested by ice and morphine, but starting again later, Meyer (Münch. med. Woch., Dec. 26, 1916) gave the patient the contents of a tube of coag-

**ulen,** a blood platelet extract. The vomiting and bleeding stopped at once. This remedy acts only on direct contact; it should be given directly after vomiting, or while the stomach is open during an operation.

Donaldson and Camac (Med. Rec., Feb. 26, 1916) have reported a case of repeated hematemesis in a girl of 19 years in which the red cells became reduced to 1,800,000, and the hemoglobin to 22 per cent. A direct vein-to-vein **transfusion** from her twin brother was followed in 2 hours by a profuse menstrual discharge, more or less continuous for 8 days. Five hours after the transfusion she was given 55 c.c. of **horse serum** intravenously. This was followed in a few hours by her seventh and last hematemesis. After 2 subsequent transfusions she improved steadily and permanently. Recovery seemed due largely to the transfusions.

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**Insomnia.**
**Etiology.**—Apart from the sleeplessness symptomatic of certain forms of mental disease, fully reviewed in the

body of this work, insomnia may arise from a number of different causes, such as pain, coughing, dyspnea, fever, mental strain or shock, intoxication, and senility. Toxic insomnia may result not only from alcoholism but from the excessive use of tobacco or of coffee or tea shortly before bedtime, or from endogenous toxic products tending to maintain cerebral hyperemia, such as those formed because of intestinal stasis, renal insufficiency, or the gouty diathesis. In senile insomnia, diminution of elasticity or possibly of vasomotor control of the cerebral arterioles is believed to be responsible. Brain tumor and cerebral syphilis are other causes. In a large number of instances the cause of the insomnia will be found to be merely an improper mode of living, frequently involving the excessive use of stimulants in the attempt to keep working at high pressure.

*Intermittent insomnia* is held at times a manifestation of periodical psychosis by Gilbert Ballet (Presse méd., Feb. 17, 1916). This variety is characterized by (1) the exaggerated stress laid by the patient on the discomforts of his sleepless periods; (2) marked depression during the daytime with lessened zest for work, and morbid preoccupations; (3) sleeplessness, often at once reaching its maximum, and later disappearing suddenly; and (4) recurrence at protracted intervals, sometimes with excitement and later depression.

**Treatment.**—The use of hypnotic drugs is, as a rule, merely a palliative measure, and since their continued employment tends toward habit formation, treatment directed toward removal of the cause of the insomnia, where this is possible, is far preferable. Such removal of the cause consists, *e.g.*, in the appropriate medical or surgical treatment of conditions causing pain, of feeble heart action in cardiac dyspnea, of bronchial or pulmonary diseases in the presence of cough, of infectious processes in the presence of fever, of constipation, renal disease, etc. In toxic insomnia the intoxicant must be withdrawn, and in that due to worry or other strain the patient removed from the harmful influence responsible. Where detection or complete removal of the cause proves unattainable, or for the purpose of encouraging the patient before the causal treatment has had time to bear fruit, medicinal or preferably hygienic, physical, and dietetic methods may be availed of. **Prohibition of mental activity in the evening,** a moderately **warm bath** or shower, followed by general **massage** and a little **hot milk** with crackers, before going to bed, are frequently effective measures. A fairly long walk or other **exercise** in the afternoon, or a short walk in the evening, may be helpful, especially in subjects with sedentary occupations. Where there is arteriosclerosis and a tendency to high blood-pressure, the **evening meal** should **be light,** and taken early. In the presence of hysteria, or even in other cases, a **placebo** of starch or prepared chalk in a capsule, coupled with forceful verbal **suggestion,** may prove highly efficacious. In some subjects, accustomed to worrying over inconsequential matters while abed, earnest recommendation that they endeavor on retiring to dismiss everything from their minds, except sleep may prove helpful. Where there is acute inflammatory pain, an **icebag** or **hot-water bag** to the involved region is often sufficient. Hot-water bottles in bed will promote sleep where the latter is interfered with by cold extremities.

Drugs should be as much as possible avoided, especially when the patient cannot be kept under close supervision. In the milder cases, the **bromides** in doses of 15 to 30 grains (1 to 2 Gm.) at bedtime, are the safest and frequently efficient remedies. **Chloral hydrate,** 8 to 20 grains (0.51 to 1.3 Gm.), is more powerful and certain in the severe cases, though at times slightly irritating to the stomach. **Veronal-sodium,** 5 to 15

grains (0.3 to 1 Gm.), acts more strongly than was originally supposed, but affords good results. **Sulphonmethane (sulphonal)**, 15 to 30 grains (1 to 2 Gm.), and **sulphonethylmethane (trional)**, 10 to 25 grains (0.65 to 1.6 Gm.), are effectual, but somewhat slower in action, especially the former. **Paraldehyde**, 30 to 60 minims (1.9 to 3.7 c.c.), is a good hypnotic, but imparts an ethereal odor to the breath for hours and even days after its administration.

**Opium** and **morphine** are of especial value where there is pain, but their use should, as a rule, be restricted to acute cases, the possibility of engendering the habit being always borne in mind. **Codeine sulphate**, ¼ to ¾ grain (0.016 to 0.048 Gm.), used for 1 or a few days, is often useful as a substitute for opium or morphine in cases attended with pain or dyspnea, in which measures directed against the underlying cause of the condition require a little time to develop their effects. **Scopolamine (hyoscine) hydrobromide**, 1/300 to 1/100 grain (0.00021 to 0.00065 Gm.), is deemed of especial value where an incessant flow of thoughts impedes the oncoming of sleep, or where the latter is disturbed by excessive dreaming. **Hyoscyamus** preparations in conjunction with chloral hydrate are sometimes used in hospitals for the insane; the **cold sheet pack**, with a covering of blankets, is a valuable adjuvant in the insomnia of insanity, and also in the presence of fever.

A combination of hypnotics in reduced doses often acts powerfully, and with reduction in the side-effects of each drug used. Alternation of hypnotics, if they must be kept up, for a period, is also advisable to reduce the probability of a gradual increase in tolerance and habit formation. For children, **sodium bromide** in appropriate doses is by many considered the best hypnotic; **ethyl carbamate (urethane)** may act more powerfully, but is less even in its effects. In some cases of chronic insomnia, as from protracted mental strain, or in nervous women, anemia seems to play a causal rôle, and should be treated with **iron, arsenic,** and a **generous diet.** In toxic insomnias and those associated with high blood-pressure, **purgation** is at times of service, tending to reduce cerebral hyperemia. In senile insomnia, frequently rather obstinate, an effort should be made to restrict medication to **bromides,** used in conjunction with physical and other non-pharmaceutic measures.

In insomnia in the presence of intestinal putrefaction with toxemia, William Martin (N. Y. Med. Jour., Jan. 1, 1916) urges a **low protein** or **protein-free diet.** In insomnia in general the bedroom should be **quiet,** well ventilated, and easily darkened. Some method of **autosuggestion,** such as counting backward or thinking of pleasant things, may be advisable. The patient should be assured, to obviate worry about not sleeping, that 10 hours of rest awake equal 6 hours of sleep. Business men with insomnia should have their **hours regulated** so that some **recreation** can be worked in, such as golf or tennis. Frequent short vacations are helpful.

**Electrical treatment** of hypertension by the autocondensation method is of great benefit in suitable cases. The static wave current to the spine, using a long narrow metal plate, with a 10- to 12- inch spark gap for 20 minutes, reduces spinal irritability and leaves a sedative effect. **Mechanical vibration** over the interspaces of the second and third, and third and fourth dorsal vertebræ helps greatly in the hypertension type of cases. Abdominal vibration with the ball vibratode will relieve splanchnic congestions, while vibration of the neck will relieve a full feeling in the head.

**Hydrotherapy** is excellent, most simply as a foot bath, with or without mustard. Iced **cold cloths** can be applied to the **head. Local packs** to the legs or abdomen may be serviceable. The **general bath,** started warm and allowed to cool till there

is decided dilatation of the skin vessels, followed by **friction** or light **massage,** is another good method. Some react well to being placed **wet** between 2 **blankets** on retiring. **Sitz baths,** heated to tolerance, with an **ice cap** or **cold cloths** to the head, forehead, and eyes, are of value in some cases.

**Psychotherapy** is advocated by L. Stein (Wiener med. Woch., Feb. 16, 1918) who believes that insomnia is the result of hyperexcitability with, perhaps, circulatory abnormalities. It reacts badly on the patient's mental condition, inspiring great mental anxiety, and even causing a durable psychic depression. To overcome these divers conditions he employs persuasion. He shows his patients that sleep is not so essential as they are led to suppose. By thus convincing the patient as to the slight importance of his insomnia, the necessary mental condition is brought about for the re-establishment of the lost function.

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Crudeness may be said to have characterized efforts to determine the functional efficiency of the kidney in past years. A healthy kidney should not permit much albumin or numerous casts to pass into the urine, but a restricted showing of these products is no longer considered as seriously as formerly. Attempts to place our knowledge of initial lesions on a sounder foundation were made some time ago, with the now virtually abandoned *methylene blue* and *indigo carmine tests* as initial efforts. The *phenolsulphonephthalein test* still maintains its hold, but it is becoming increasingly evident that it fails to give a true idea of the functional efficiency of the renal filter, unless certain parts of its structure be affected.

In recent years *creatinine elimination* seems to have afforded better results not only for the determination of renal function but also for the differentiation of structures that are the seat of lesions from those that are free of them. The test is based on the fact that the creatinine elimination of a subject on low flesh intake is remarkably constant from day to day and hour to hour. As carried out by Detwiler and Griffith, the procedure is as follows: The patient is placed on a diet in which extremes in the consumption of animal protein and fluids are avoided. The urine is then collected in 6-hour periods for 3 successive days. On the morning of the second day 1.5 grams of creatinine is given

per os, or subcutaneously. In normal persons there is a marked rise in the creatinine output in the first 6-hour period following the injection, a moderate rise in the second, and a return to the normal level in the third. In patients with diseased kidneys the initial rise is less marked, and the return to normal slower. The test shows functional disturbances of the kidneys better than any other. In general, chronic cases show more change in the nervous supply than acute cases, and there is especially a marked departure from normal in cases where uremia is imminent. Chronic passive congestion of the kidneys shows considerable disturbance.

Estimation of the *creatinine of the blood* in nephritis is deemed valuable by Myers and Lough as a diagnostic and prognostic test. They use a modified Folin method, oxalated and laked blood being saturated with picric acid, filtered, treated with sodium hydroxide, and then compared colorimetrically with a standard creatinine solution, to which the alkali has also been added. A rise above 2.5 mg. in 100 c.c. of blood signifies renal involvement almost invariably; values of 2.5 to 3 mg. are suspicious, of 3 to 5 mg. decidedly unfavorable, and over 5 mg. probably indicate early death. Pronounced retardation of creatinine excretion may indicate interruption of pregnancy.

An important feature in this connection is that, as pointed out by Fine, probably the earliest indication of interstitial nephritis is *uric acid retention,* an index of a gouty state. As the severity of the case increases the urea-nitrogen begins to accumulate followed by *creatinine accumulation,* which thus indicates a serious derangement of function, or nephritis. This condition is often accompanied by *hyperglycemia,* without glycosuria in many instances, and indicating a concomitant or complicating diabetes mellitus, though at the time unrecognized as to the usual manifestations of this disease.

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**Lactosuria.**

Milk-sugar is frequently found in the urine of nursing women, usually in very small amounts, although it may be as much as 3 per cent., and give rise to the usual symptoms of diabetes. Lactose is nearly always present two or three days after confinement, and just before milk appears (milk fever); it may also occur a day or two after weaning. Any cause that prevents the milk escaping from the breasts, *e.g.*, mastitis, may cause lactosuria.

**Detection of Lactose.**—If the urine gives a positive Fehling's test, and also causes extreme deflection of the polarized ray to the right, lactose is probably present. The urine is next treated with an excess of lead acetate, filtered, and to the filtrate ammonia added until a permanent precipitate forms. The fluid is then heated, but not boiled. If a rose-red color does not gradually appear lactose is present.

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**Lipuria.**

Normal urine contains slight traces of fatty matters—palmitins and stearin—about 2 grains (0.13 Gm.) per gallon (4.54 liters). Lipuria is physiological in pregnancy. Roberts has recorded several cases of pure oil in the urine after ingestion of codliver oil. Small quantities of fat have been met with in chronic parenchymatous nephritis, fatty renal changes, acute yellow atrophy of the liver, phosphorus poisoning, diabetes mellitus (often alternating with sugar), hydronephrosis, heart disease, pancreatic disease (oil noted in urine before appearing in stools), after fractures, and in chyluria. Much fat renders the urine turbid or milky.

*Detection of Fat in Urine.*—Under the microscope fatty matter appears in highly-refracting globules of various sizes, with dark margins.

*Ether Test.*—Shake the urine, add an equal volume of ether, shake again, cork tightly and set aside until

the ethereal portion has risen to the top. Pour it off, and allow to evaporate. The residue will show if fat or oil is present. Fat in a milky, opaque urine strongly indicates chyluria, *q.v.*, iii. 339; viii. 543.

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**Mastoiditis,** acute,

**Symptoms.**—These comprise severe pain in the mastoid region, tenderness, fever, and usually swelling of the auditory meatus above and posteriorly. Where a discharge from the meatus in acute otitis suddenly stops and remains in abeyance for more than a few days, mastoiditis requiring operation is likely to develop.

**Etiology.**—Tuberculosis, syphilis, or trauma of the mastoid may induce an apparently primary mastoiditis, in which, if caries of the bone occurs, the abscess cavity is generally not connected with the tympanum. Almost always, however, mastoiditis in any of its forms is a consequence of pre-existing acute or chronic suppuration of the middle ear.

**Prognosis.**—In the most acute cases, usually streptococcic, only a few days may separate the initial symptoms and the moment at which surgical evacuation of the mastoid becomes indicated. In other cases slight tenderness on deep pressure and mild shooting pains through the mastoid may persist for weeks, and operation remain unnecessary, a fluctuating swelling finally appearing over the mastoid or the digastric fossa, or more deeply in the neck tissues, the result of perforation of the bone and passage of pus into the soft tissues. Tenderness of the mastoid occurring in the course of acute suppurative otitis media will usually soon disappear under treatment. In cases later in advent, recovery will occur in the majority of cases without operation provided streptococci or the influenza organism are not causative and provided the postero-superior tissues of the auditory canal are not inflamed. Occasionally, however, mastoid disease extends inward and causes lateral sinus phlebitis, thrombosis, and embolism. Subdural abscess, basal or otherwise situated meningitis, and brain abscess are also possible complications.

**Diagnosis.**—A pushing out of the auricle from the head, when viewed from behind, is deemed significant of mastoiditis, enlargement of the small lymph node over the surface of the mastoid not causing this condition. A bacteriologic examination of the discharge should be made, as the type of organism found governs the urgency of operative treatment. The X-rays are of diagnostic value, serve to show the size and extent of the mastoid cells in the individual case, and assist in convincing the patient of the necessity of an operation, where indicated.

**Treatment.**—Pain may be combated with a **hot water bag** or **ice-bag,** and if necessary an analgesic drug given. Hourly irrigations with 1:5000 **hot bichloride solution** and **Bier's hyperemia** with a constricting band around the neck 4 times a day, with 2-hour intervals between treatments, have also been recommended. **Shrapnell's membrane** should be **incised** when its posterior part, together with the surrounding meatal tissues are found congested, and a 20 per cent. **ointment of ichthyol** in wool-fat may with advantage be applied over the mastoid.

Operative treatment is indicated where the above measures, coupled with proper management of middle ear suppuration, fail to give relief. Where some doubt as to its necessity exists it seems wise to incline toward the intervention, both the danger to life and that of loss of hearing being greatly reduced by the operation, which entails little risk.

The customary operative procedure is the simple mastoid or **Schwartze operation.** The incision is made from the tip of the mastoid to a point above the helix, and passes rather close to the auricular attach-

ment. It is continued upward almost to the temporal artery, and should penetrate to the bone, the periosteum being cut through. The lips of the wound may be held apart with Jansen dilators above and below, after the periosteum has been carefully raised for some distance. The cortex of the mastoid, if softened, is then rather easily removed with bone forceps or curette, and any abscess cavity found scraped clean down to normal bone with the curette, special care being taken at the points where the lateral sinus and aqueduct of Fallopius might be injured. The mastoid antrum should then be thoroughly opened up and the bone above and behind the meatus, at roof of the zygoma, chiselled away to obviate sinus formation from cells overlooked in this locality. In cases of von Bezold's abscess, due to perforation toward the midline on the inner surface of the mastoid process, the whole tip of the mastoid should be removed and the underlying abscess cavity well opened up. In cases in which the mastoid, upon exposure, shows no area of softening or sinus opening, entrance into the mastoid is effected with a chisel and mallet, in a safety space called triangle of Macewen or suprameatal triangle, bounded in front by the posterior wall of the meatus, above by the linea temporalis, and behind by the remains of the squamomastoid fissure. The antrum will be penetrated at a depth of 12 to 22 millimeters from the surface, the operator proceeding with great caution in the latter part of this distance. Upon working in a direction slightly upward and parallel to the auditory canal, a right-angled probe, passed into the vault of the tympanum through the meatus, will eventually be encountered, with relative safety. The wound and meatus are then thoroughly cleaned with warm sterile water, and the former allowed to fill with a blood-clot (in absolutely clean cases only) or prepared for healing by the open method.

Harold Hays (N. Y. Med. Jour., Nov. 11, 1916) asserts that in cases which do not respond to treatment, and where sinus thrombosis and epidural abscess are set up, the X-rays frequently determine the condition of the underlying bone before extensive destruction has taken place.

If, in acute mastoiditis, one can maintain good drainage through the drum, many cases may be aborted, according to J. W. White (Va. Med. Semi-Mthly., Mar. 9, 1917). The canal should be examined daily, and if there is the slightest pus retention, several **myringotomies** should be done if needed, and the **canal irrigated** with some hot solution every 2 or 3 hours. In the aged, however, in acute mastoiditis superimposed on a chronic middle ear suppuration, immediate **operation** is indicated. If pain persists, although there is good drainage from the ear, operation is called for. If headache is severe, a **lumbar puncture** should be done. The smouldering cases with streptococcus mucosus capsulatus infection should not be watched longer than 3 weeks.

Middle-ear involvement which does not resolve in 2 weeks means, according to E. B. Dench (N. Y. Med. Jour., Mar. 18, 1916), mastoid disease demanding at least exploratory operation. Tenderness after the fourth or fifth day is of great significance, especially if over the antrum. Narrowing of the external auditory meatus near the drum, is the most reliable sign of all. The drum membrane may appear nearer to the entrance of the canal than normally. General symptoms of diagnostic importance are persistent headache and sleeplessness. Absence of temperature and the differential blood-count are relatively unimportant. Recurring attacks of acute otitis point to mastoid involvement.

Irrigation with **Dakin's solution** and **drainage** according to Carrel's

technique are urged by Mahu (Presse méd., Apr. 5, 1917), for a period before closing the wound after operation for acute mastoiditis. One or 2 teaspoonfuls of Dakin's fluid are used for irrigation every 2 hours, under a pressure of 60 or 80 centimeters. When the germs in the discharge are reduced to 1 per microscopic field, he **sutures** the wound entirely. Complete healing is thus obtained in one-third the usual time.

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**Symptoms.**—At times there is little or no pain. The condition may not be suspected until examination reveals congestion of Shrapnell's membrane, associated with postero-superior swelling in the meatus. Enlargement over the mastoid or of the tissues below the ear may, however, suggest the condition from the exterior. Where perforation has occurred, the typical pushed-out appearance of the auricle will be noted on posterior inspection.

**Pathology.**—Usually the mastoid antrum is occupied by cholesteatomatous masses, *i.e.*, accumulations of epithelial scales, dried pus, and cholesterin crystals. These masses are apt to shut off the mastoid cells from the tympanic cavity. Almost complete obliteration of the cells may also result from thickening of the tissues adjoining a carious portion of the bone. Where no suppuration has occurred in the preceding active inflammation, consolidation of the mastoid by hyperostosis may be induced in the absence of bone caries.

**Treatment.**—The Schwartze or simple mastoid operation often fails to completely cure the condition where there has been chronic suppuration. In 1891 **Stacke** introduced the radical mastoid **operation,** which, as at present performed, aims to throw together into a single cavity the mastoid cells and antrum, the middle ear, and the auditory canal, after thorough removal of all diseased tissue. The antrum is first opened as in the simple mastoid operation, and the cartilaginous portion of the canal with the periosteum separated from the bony canal by elevation, incision, and traction. The bony canal is now chiselled off down to the annulus tympanicus, care being taken not to endanger the facial nerve. The bony external wall of the attic and aditus is then gouged and curetted off, the tendon of the stapedius muscle and the incudostapedial articulation severed, and removal of the malleus and incus affected. The external walls of the antrum, attic, and hypotympanic space are next curetted away to eliminate projecting bony margins and round out the cavity as a whole. Finally, oozing is checked, and as much as practicable of the cavity remaining lined with flaps of skin from the meatus and the concha. The uncovered area is permitted to heal by granulation or grafted at the operation or later with Thiersch grafts. Behind the auricle the periosteum is first sutured, then the subcutaneous tissues and skin. Through the enlarged meatus a small cigarette drain is inserted and a gauze dressing applied. A paste composed of scarlet red, 1 part, and Beck's paste, 3 parts, has been suggested by Myles for use in the after-treatment. Harris in 1917 pointed out that improvement in hearing from the radical operation cannot be promised. Where the disease is limited to the antrum and mastoid cells the simple operation should prove sufficient.

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**Phosphaturia.**

Phosphaturia signifies a persistent excess of phosphates in the urine. Phosphorus exists in normal urine in combination with the alkalies (potassium, sodium, ammonium) and the earths (calcium, magnesium). Only the latter are met with as urinary deposits. The earthy phosphates are the triple or ammonio-magnesium phosphate, and calcium or lime phosphate. They are held in solution by urinary acidity. When the urine becomes neutral or alkaline they are precipitated; also by heat, especially when in excess or when the urine is but faintly acid. Addition of dilute acetic acid will dissolve

the precipitated phosphates, and thus differentiate them from albumin and pus. The alkaline phosphates are present in larger amount (about two-thirds of the total phosphoric acid).

The phosphates are normally *increased* by ingestion of phosphoric acid and soluble phosphates; by excess of protein food; and by nerve strain. Pathologically they are increased in inflammatory diseases, traumatic meningitis, acute rheumatism, rickets, extensive bone-disease, and "phosphatic diabetes." They are normally *decreased* during pregnancy; pathologically, in maniacal paroxysms, melancholia, general or sexual exhaustion, nephritis, and dyspepsia.

**Detection of the Phosphates.**—Phosphatic urine usually has a stale, ammoniacal odor, a whitish turbidity, and a copious light-colored granular sediment after standing. Microscopical examination reveals calcium phosphate either as amorphous, minute, pale granules arranged in irregular patches, or as crystals appearing singly in "knife-blade," "arrow-head," or "slender-wedge" shape, or in stellate clusters. The crystalline form is rare. The ammonio-magnesium phosphate crystals are transparent, rhombic or triangular prisms, "coffin-lid"-shaped. All the above are soluble in acetic acid. Calcium oxalate crystals are not.

*Heat Test.*—The earthy phosphates are precipitated by adding sufficient ammonia to make the urine distinctly alkaline, and applying gentle heat. Filter the earthy phosphates out, and add to the same urine a saturated solution of magnesium sulphate, to obtain the alkaline phosphates.

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**Venomous Wounds and Stings.**

These comprise the injuries inflicted by insects or arachnids, snake bites, and rat-bite fever.

**Stings by Insects and Arachnids.**—As a rule, the lesions produced are purely local, exciting no constitutional manifestations. This applies, *e.g.,* to the bite of the common Culex *mosquito.* Over such bites **menthol** in crystalline form or as menthol-camphor may be applied, often with considerable relief. **Ammonia water,** useful to neutralize the strongly acid poison introduced by most insects in stinging, will often reduce suffering in mosquito bites if promptly brought and kept in contact locally for a few moments. Similar measures are applicable in *sand fly* **bites** and those of the *diablito colorado* ("little red devil") of the tropics. For *bee, wasp,* or *hornet* stings, 5 per cent. **potassium permanganate** solution has been recommended.

**Spirit of ammonia** is a favorite application. In bee stings the barbed sting left in the tissues may sometimes with advantage be removed by means of fine forceps and a magnifying lens. According to G. King, powdered **ipecacuanha,** made into a paste, will largely prevent local swelling and pain in bee stings. Ottinger, in all venomous insect bites, recommends **ichthyol,** pure or mixed with **wool fat;** if the part is already swollen, **rubber sheeting** and **ice** are applied over the ichthyol.

In *jigger bites,* radical treatment consists in removing with a fine needle the skin from the little ball or nest produced by the insect, pressing the ball out between the fingers, and filling the cavity with some antiseptic to kill any remaining eggs. Mexican guides destroy the embedded insect by applying a lighted cigarette to the spot.

In the case of *wood ticks* the head of the insect should be extracted from the tissues with a needle or knife; or, **turpentine** or any essential oil applied to the insect posteriorly may cause it to loosen its hold. A drop of **chloroform** may be injected locally for the same purpose.

Stings of *scorpions* and *poisonous spiders* and *centipedes* are relieved by the local use of a weak solution of **phenol. Camphor, potassium permanganate, rum,** or **lemon juice** may also prove serviceable. Where constitutional depression is noted after bites by these or other venomous invertebrates, **rest** and **stimulants,** especially **strong coffee,** are indicated. In severe spider bites local injection of 5 per cent. **permanganate** may prove advantageous.

In insect bites complicated by bacterial infection, *e.g.,* in many bites by horse flies or deer flies, the usual principles of treatment for local infection are applicable, viz., **tincture of iodine, moist antiseptic dressings,** and **incision** when opportune.

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**Prophylaxis** of insect bites for travellers, soldiers, and others exposed, comprises the use of a strong **carbolic soap** for washing, moistening exposed parts with a solution of 1 ounce of **phenol** in a bucketful of water (without wiping), or the external use of an **emulsion of kerosene** or **petroleum. Oil of citronella** and **camphor in alcohol** are of some value as mosquito bite preventives.

**Snake Bites.**—Of the 25 or more species of venomous snakes of the United States the commonest are the rattlesnake, copperhead, and moccasin. The venomous snakes, as a class, are characterized by a triangular head, relative plumpness of body, apparently rough surface, elliptical pupils, and a pit or depression between each eye and the corresponding nostril. After all bites by poisonous snakes, including the various tropical forms, the symptoms comprise a gradually increasing pain, infiltration and ecchymoses of the surrounding tissues, and general effects, such as central respiratory depression, im-

paired heart action, drowsiness, cold sweats, vomiting, and prostration. Death from cardiac paralysis may ensue in a few hours or, after a day or two, the poisonous action on the blood and other tissues may result in mental disturbances or exhaustion and coma. As a rule, however, the prognosis is unfavorable only in previously enfeebled subjects or children.

In the treatment the first step should be to **tie** a **cord** or **handkerchief** tightly **about the bitten limb,** above the wound. **Suction** of the wound may then be practised—in the absence of syphilitic infection—providing the lips be not cracked nor the oral mucosa abraded. The **part bitten should** then **be excised,** using a penknife if necessary, and the part allowed to bleed freely. Where the skin can be pinched up it may be cut off with scissors, deeper tissues being subsequently removed if necessary. **Cauterization** with a hot iron is less reliable than excision. Chemical destruction of the poison is a possibility, a 1 to 5 solution of **potassium permanganate** or strong **ammonia** being injected into the wound with a hypodermic syringe. According to White, the best chemical antidote is a 2 per cent. solution of **hypochlorite of lime.** F. Howard administers internally 1 tablespoonful of **potassium nitrate** in a glass of water (1 teaspoonful in a child under 10 years). Symptomatic general treatment consists in antagonizing the depressing actions of the venom by means of **ammonia preparations, whisky** or **brandy, digitalis, strychnine,** etc., hypodermically or by mouth.

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**Rat-bite Fever.**—This is an infection following the bite of a rat or, much less frequently, a cat, weasel, or ferret. In Japan, where it has been commonest, the disease is termed *Sokodu.* Cases have also been met with in America—including the United States—Europe, and other countries of Asia. The causative agent has been supposed to be the *Streptothrix muris-ratti* of Schottmüller (Dermatol. Woch., 77, lviii, 1914), likewise found clinically by F. G. Blake (Jour. of Exper. Med., 39, xxiii, 1916), but according to Japanese investigators—Futaki, Takaki, Taniguchi, and Osumi (Jour. of Exper. Med., 33, xxv, 1917)—it is a protozoön, *Spirochæta morsus-muris.*

**Symptoms.**—The incubation period ranges from 1 to 60 days, averaging 2 weeks. According to Wilder Tileston (Jour. Amer. Med. Assoc., Apr. 1, 1916), this is followed by 1 or more febrile attacks, with a characteristic rash, the paroxysms tending to recur regularly every 5 to 10 days, and lasting 2 to 3 days. The temperature rises gradually to the second day, then falls by crisis, with profuse sweating. Severe muscular pains and dysphagia are often prominent. In the intervals the patient feels almost well. In occasional cases there is only 1 attack, the fever lasting for several weeks, and being remittent or intermittent. Abortive and febrile forms occur. The mortality is 10 per cent.

**Prophylaxis and Treatment.**—The former consists in **immediate cauterization** of the wound with strong **phenol** or the **actual cautery.** In the curative treatment, **salvarsan** is followed by immediate cessation of the paroxysms. K. Nakasone (Sei-I-Kwai Med. Jour., Jan. 10, 1916), among others, has reported 2 cases thus promptly cured.

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**Vertigo.**

**Etiology and Diagnosis.**—Primarily this symptom or subjective sensation is due to some disturbance of the various structures taking part in the maintenance of the equilibrium of the body. These structures include the nerve paths which convey sensory impressions from various organs, the eyes, spinal cord, tactile organs, the nerves of pressure and tension sense, from the muscles, joints and internal organs, etc., and their centers. While vertigo is in general terms attributable to disturbance of the vestibular nerve and its connecting fibers in the semi-circular canals, the latter are only portions, though important as such, of the mechanism of equilibration and orientation, for destruction of the canals is followed sooner or later by return of these functions. This shows that the centers referred to should not be overlooked in the genesis of vertigo; particularly where toxemias occur as cause.

True aural vertigo may be due to labyrinthine effusion (Mémère's disease, *q.v.*), progressive middle-ear disease, a hemorrhage into the labyrinth, as for instance, in arteriosclerosis, or to traumatism. It may also be caused either by high or low blood-pressure. Progressive middle-ear disease, accompanied with deafness, and arteriosclerosis have been regarded by Lake as the most frequent causes. As differentiated from vertigo of ocular origin *aural* vertigo, according to W. R. Murray (Journal-Lancet, Dec. 1, 1913), is a disturbance of equilibrium with nystagmus, *i.e.*, an alternating rapid and slow movement of the eyeballs, the vertigo being increased by turning the eyes in the direction of the rapid movement. *Ocular* vertigo on the other hand is usually associated with muscular imbalance and astigmatism. If a careful examination of the eyes and correction fail to relieve the symptom, and there is headache, organic cerebral disease is to be suspected, particularly if there is any degree of optic neuritis, or ophthalmoplegia.

Acute vertigo may occur suddenly as a result of traumatisms, blows, explosions, concussion, etc., often owing to labyrinthine hemorrhage; or in the course of infections, owing to acute labyrinthitis. It may also attend toxemias due to deficient hepatic activity and renal insufficiency, intestinal autointoxication, or, as is frequently the case, digestive disturbances, *i.e.*, gastric vertigo. Various drugs, quinine, for instance, may also cause it besides tinnitus aurium. The acute type may be accompanied by unconsciousness as a part of the aura of epilepsy for example, or the syncope of cardiac failure, owing to ischemia of the labyrinth and equilibrium centers. It usually attends laryngeal vertigo or syncope.

Closing of the eyes is a helpful test in determining the cause of vertigo in a given case. Where relief is afforded by closing the eyes the disorder present is not an organic one, but purely functional, as in neurasthenia or hysteria, astigmatism, and other purely functional disorders of vision. Where aggravation of the vertigo occurs on closing the eyes, locomotor ataxia is to be suspected. When unaffected by the same procedure, the symptom is either of cardio-vascular origin, with ischemia or congestion of the cerebro-aural organs as result, or due to some toxemia, hepatic, renal, gastric, or intestinal, often with migraine of gouty origin, or to some cerebral organic disease.

**Treatment.**—This of course reduces itself to removal of the original cause in each case, as given under the various headings of the many causative disorders enumerated above. Palliative measures which are also useful are enumerated below.

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